

MISSOURI DEPARTMENT OF MENTAL HEALTH

KEITH SCHAFER, DEPARTMENT DIRECTOR



DEPARTMENT
OPERATING
REGULATION
NUMBER

DOR
4.152

CHAPTER Program Implementation and Records	SUBCHAPTER Clinical Standards and Procedures	EFFECTIVE DATE 7/1/09	NUMBER OF PAGES 6	PAGE NUMBER 1 of 6
SUBJECT Administration of Psychotropic Medications Involuntarily		AUTHORITY Section 630.050, RSMo		HISTORY See Below
PERSON RESPONSIBLE Director, CPS			SUNSET DATE 7/1/12	

PURPOSE: Prescribes procedures for involuntary administration of psychotropic medications.

APPLICATION: Applies to Division of Comprehensive Psychiatric Services hospitals and mental health centers. In addition to adults, this DOR does apply to any individual under 18 years of age who has been certified to stand trial as an adult and placed with the Department pursuant to Chapter 552 or 557, RSMo, or Chapter 632, RSMo. This does not apply to other minors.

(1) EMERGENCY PROCEDURES:

All patients in the Department of Mental Health facilities may be administered psychotropic medication on an involuntary basis when a determination of emergency is made by appropriate clinical personnel at the facility. An emergency exists where there is reasonable likelihood of physical harm and/or life threatening behavior to the patient or others. The treating psychiatrist who prescribes the psychotropic medication shall document the circumstances of the emergency and the facts surrounding the medication need.

(2) NON-EMERGENCY PROCEDURES (By Legal Status):

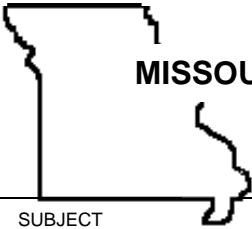
Involuntary medication administration is defined as administration of any psychotropic medication when the patient has verbally expressed refusal to take medication in front of a witness or in writing.

(A) Court Order: It is permissible, regardless of the patient's legal status, to recognize a court order which specifically authorizes the involuntary administration of psychotropic medication.

(B) Pre-Trial Evaluations: The following are guidelines for patients committed for pretrial evaluations: No patient committed for a pretrial evaluation may be medicated, absent an emergency, without expressed, written consent from the committing court, or from the patient. The psychiatrist must communicate his/her desire to medicate such a client to the committing court and obtain a written order from the judge.

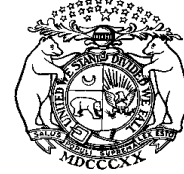
(C) Civil Involuntary Patients and Incompetent to Stand Trial:

1. The treating physician who prescribes the psychotropic medication shall document the facts surrounding the need for medication. Specific reason(s) why psychotropic medication is indicated, i.e., including but not limited to, that the treatment is appropriate for the diagnosis; the specific psychotropic medication; the possible side effects and that involuntary psychotropic medication is least restrictive treatment should be listed. Factors that may have led to the refusal, i.e., type of medications and type of



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side effects, dosage of medication, history of past response, patient's behaviors, etc., should be documented.

2. A consultation by a second psychiatrist shall be obtained covering the same areas as under (C) 1.

3. If the treating psychiatrist and second consulting psychiatrist disagree, the medical director of the facility shall be the final decision maker. No further appeal shall be allowed.

(D) Voluntary Patients With Guardians: The following are guidelines for voluntary patients by guardian:

1. If the patient is adjudicated fully incompetent or granted a limited guardianship where medical needs are the basis of the guardianship and psychotropic medication is identified as a part of the treatment plan, the guardian shall be informed of the need and written consent, or telephone consent with a second staff member participating as a witness, obtained from the guardian. If the consent is obtained by telephone, one of the two persons receiving the consent shall be a nurse.

2. Every effort shall be made to address the reasons for objections by the guardian.

3. If the guardian refuses to authorize that the patient is to receive psychotropic medication, the patient may be discharged from the program only if medication is the primary treatment available for the patient's condition.

4. The guardian's permission overrides any patient objection or refusal.

(E) Voluntary: The following are guidelines to be followed by facility staff for voluntary patients:

1. Voluntary patients have the absolute right to refuse psychotropic medications, except in an emergency.

2. Patient's verbal refusal or written refusal shall be made a permanent part of the patient's medical record.

3. Once refused, the patient shall be provided written notice stating specific reason(s) why psychotropic medication is indicated, i.e., including but not limited to, that the treatment is appropriate for the diagnosis; the specific psychotropic medication; and the possible side effects; and involuntary psychotropic medication is least restrictive treatment;

4. A psychiatrist must evaluate a patient to determine the following:

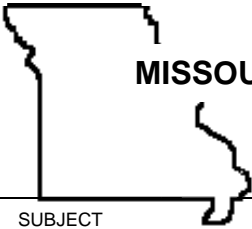
a. whether the patient is dangerous and presents a reasonable likelihood of physical harm;

b. whether the patient is competent. If the patient is competent, his/her refusal should be respected, provided an emergency does not exist.

5. The patient may be discharged from the hospital or from the program if:

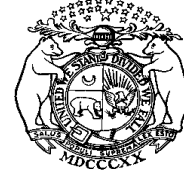
a. medication is the only primary treatment for the patient's condition;

b. no other treatment is suitable for the patient's condition; and,



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c. the patient is competent and does not present a reasonable likelihood of serious physical harm to self or others.

6. If the patient is competent, not imminently dangerous, and alternate therapies are available, the patient may not be discharged from the program solely based on refusal to take medications.

7. If the patient is determined incompetent but not imminently dangerous, clinicians shall proceed by filing for guardianship. Until the guardianship process is completed, the patient's refusal to take medication should be honored, unless an emergency exists.

8. If the patient presents likelihood of serious physical harm to himself or others, the patient's voluntary status should be changed to civil involuntary status, and the guidelines of item (c) of this DOR should be followed.

(F) Individuals under 18 years of age who have been certified to stand trial as an adult, and placed with the Department pursuant to Chapter 552, 557 or 632, Revised Statutes of Missouri: The following are guidelines for patients committed under Chapter 552, 557 or 632, RSMo:

1. If the patient has a parent(s) whose rights have not been previously formally terminated by the juvenile court, the parent(s) shall be informed of the need for medication and written consent obtained from the parent(s).

2. If the patient has a legal guardian other than the parent(s), that guardian shall be informed of the need and written consent obtained from the guardian.

3. If there is no parent and/or no other legal guardian, ascertain whether there is another agency, i.e. DFS, that has legal custody. If so, that agency shall be informed of the need and written consent obtained from the agency representative.

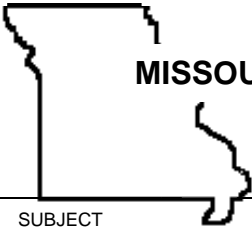
4. If the patient was committed for a pretrial evaluation, he shall not be involuntarily medicated without expressed, written consent from a committing court unless an emergency exists as defined by (1) of this DOR, or unless the patient consents to such medication.

5. If the patient was committed to DMH as incompetent to proceed or not guilty by reason of mental disease or defect, all consents as set forth in (2) (F) 1, 2, and 3, or a request made to the committing court for such involuntary medication, shall be sought.

6. If there is no parent, legal guardian, or agency with legal custody available to consent, the steps for administration of involuntary medication as set forth in (2) (G) shall be followed. The only change to this process shall be that the second opinion shall be conducted by a psychiatrist that has five (5) years recent experience providing psychiatric treatment to children and youth.

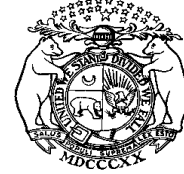
(G) Not Guilty by Reason of Mental Disease or Defect Commitments pursuant to Section 552.040, RSMo: The following are guidelines to be followed by facility staff for patients not guilty by reason of mental disease or defect commitments:

1. Patient's verbal refusal or written refusal shall be made a permanent part of the patient's medical record.



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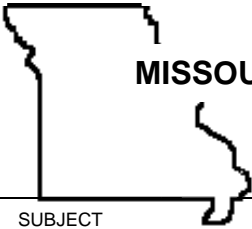


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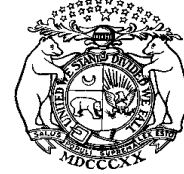
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2. Once refused, the patient shall be provided written notice stating:
 - a. specific reason(s) why psychotropic medication is indicated, i.e., including but not limited to, that the treatment is appropriate for the diagnosis; the specific psychotropic medication; and the possible side effects; and involuntary psychotropic medication is least restrictive treatment;
 - b. specific reason(s) why the patient is dangerous and presents a reasonable likelihood of physical harm; and
 - c. that a second psychiatrist opinion has been requested and that the patient shall be afforded an interview with the second psychiatrist.
3. Requirements of the second opinion for patients who are not guilty by reason of mental disease or defect commitments:
 - a. All interviews shall be audio taped (said tapes shall be transcribed upon appeal). If sign language is used a videotape will be done.
 - b. All second opinions must be from a psychiatrist who is not primarily responsible for the patient's treatment currently or in the 12 months preceding the request for the second opinion.
 - c. The patient may be assisted in the second opinion process by an independent lay advisor of his own choosing. The Department of Mental Health facility will maintain a list of those individuals who wish to serve as lay advisors. These individuals would serve without expense to the patient. Any non-Department of Mental Health advisor would be at the patient's own expense.
 - d. The treating psychiatrist shall have documented the factors that may have led to the refusal, i.e., type of medications, type of side effects, dosage of medications, history of past response, patient's side effects, dosage of medications, patient's behaviors, patient's religious or cultural bias, etc. This history must be available to the second psychiatrist as soon as possible
 - e. The psychiatrist offering the second opinion shall have an interview with the patient to hear and document all of the patient's reasons for refusal. A second psychiatrist's opinion shall specifically include a review of the initial psychiatrist's reason for prescribing medication; the patient's reason(s) for objecting; and the subsequent basis for the second opinion, including but not limited to the indications of the need for psychotropic medication and whether the patient is dangerous and presents a reasonable likelihood of physical harm. This written evaluation shall be provided to the patient.
 - f. This process shall be completed within 10 (ten) working days of the referral.
 - g. If the treating psychiatrist and second psychiatrist agree that the patient should be medicated, the patient may appeal in writing to the medical director or designee within 5 (five) working days of the receipt of the written decision. Within 5 (five) working days of such notice of appeal, the medical director or designee shall render a written decision to the patient affirming or overruling the decision to medicate.



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h. When the treating psychiatrist and second psychiatrist opinion disagree, the medical director of the facility or designee shall be the final decision maker.

i. If the decision to medicate is affirmed, that decision may then be appealed to Central Office to the Deputy Director of Psychiatry for the Division of Comprehensive Psychiatric Services within five (5) working days, and the Deputy then has 10 (ten) working days to affirm or overrule the medical director's decision. Written notice of the Deputy Director's decision shall be provided to the patient and the facility.

j. For all such cases involving individuals under 18 years of age who have been certified to stand trial as an adult, the designated Certified Forensic Examiner for Children and Youth shall be notified.

(3) **INVOLUNTARY MEDICATION ADMINISTRATION SUBSEQUENT TO SECOND OPINION AND APPEAL:** If involuntary medication is instituted, such medication may continue for a period of 30 (thirty) days. If refusal continues, a written statement is given to the medical director as to the need for continued medication if patient continues to refuse. This written statement shall include progress with treatment; side effects (if any); and justification for continued use. Thereafter, the treating psychiatrist shall send a similar notice to the medical director on a monthly basis. The procedures outlined in section (2) above shall be reinstated at 6 (six) months if involuntary medication is continued if refusal continues. If the status changes from involuntary to voluntary and the patient then refuses, section (2)(E) applies.

(4) **REFUSAL OF MEDICATION DUE TO RELIGIOUS BELIEF:**

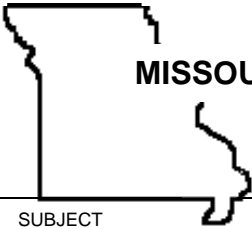
(A) Any patient not under guardianship who is currently an active, practicing member of a generally recognized, organized church or religion which teaches reliance upon treatment by prayer or other spiritual means of healing may refuse the administration of medication except in an emergency (see (1)).

(B) Whenever a patient seeks to refuse medication due to religious belief, the superintendent shall convene and chair a review panel consisting of a facility chaplain, a licensed social worker, a psychologist and the medical director. The panel shall seek advice from an outside member of the patient's religion or church whenever possible. The panel shall interview the patient, review records, and seek outside advice and confirmation that:

1. the patient's religion is a generally recognized, organized faith which teaches reliance on spiritual means;

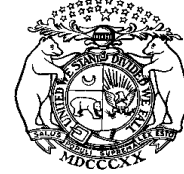
2. the patient has been and is currently an active participating member.

(C) If the review panel confirms (B) 1 and 2, the patient's refusal of medication shall be honored. If either (B) 1 or 2 are not confirmed, the refusal will be handled as set forth under (2) Non-Emergency Procedures.



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HISTORY: Original DOR effective January 1, 1995. Amendment effective July 1, 1997. amendment effective May 1, 1997. Amendment effective October 1, 2002. On July 1, 2006 the sunset date was extended to July 1, 2009. On July 1, 2009, the sunset date was extended to July 1, 2012.